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ACRONYMS

AMHOP	-	Association of Municipal Health Officers of the Philippines
BF/W	-	Breastfeeding and Weaning
BUCEN	-	(U.S.) Bureau of Census
CARI	-	Control of Acute Respiratory Infection
CDD	-	Control of Diarrheal Diseases
CDLMIS	-	Contraceptive Delivery and Logistics Management Information System
CYP	-	Couple Years of Protection
DHS	-	Demographic and Health Survey
DOH	-	Department of Health
EPI	-	Expanded Program on Immunization
FHSIS	-	Field Health Services Information System
FPS	-	Family Planning Service
HES	-	Human and Ecologic Security
HIS	-	Health Information Service
IFPMHP	-	Integrated Family Planning Maternal Health Program
LGUs	-	Local Government Units
LPP	-	Local Government Performance Program
MCH	-	Maternal and Child Health

MCHS	-	Maternal and Child Health Service
MCP	-	Maternal Care Program
MIS	-	Management Information System
MSH	-	Management Sciences for Health
NDS	-	National Demographic Survey
NHS	-	National Health Survey
NS	-	Nutrition Service
NSO	-	National Statistics Office
OPHS	-	Office for Public Health Services
PFPP	-	Philippine Family Planning Program
PNGOC	-	Philippine NGO Council on Population, Health and Welfare, Inc.
SA	-	Situational Analysis
SEAMIC	-	Southeast Asian Medical Information Center
UFC	-	Under Five Care
UNFPA	-	United National Population Fund
USAID	-	United States Agency for International Development
WHO	-	World Health Organization
WHSMP	-	Women's Health and Safe Motherhood Project

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EXECUTIVE SUMMARY

Over the past ten years, the Department of Health's (DOH) family planning (FP), nutrition, and maternal and child health (MCH) services have relied heavily on information from the then Health Information System (HIS), more recently from the Field Health Services Information System (FHSIS), and on occasional national and provincial surveys conducted by the DOH and other institutions like the National Statistics Office and Food and Nutrition Research Institute. Since 1990, the FHSIS has been the DOH's principal monitoring system for 12 public health programs, but it has struggled for adequate resources as well as reliability with the recent devolution of health care to Local Government Units (LGUs). Family Planning Service (FPS) has gone directly to the regions for FHSIS data when data were unavailable nationally, but Maternal and Child Health Service (MCHS) has not had data regularly from FHSIS since devolution. The FHSIS reporting to LGUs and the DOH has recently been simplified and pilot tested, and a modified version is being implemented nationwide.

The presence of parallel systems of data collection activities in support of FP, nutrition and MCH services, points to the absence of a comprehensive FP, MCH and nutrition MIS strategy for the DOH. A viable MIS strategy for FP, nutrition and MCH services demands that the DOH and LGUs coordinate information activities and share in their funding. In a post-devolution era, LGUs are mandated to assume considerable responsibility for monitoring and evaluating the services they deliver as the DOH adapts to its new role of setting the national agenda and providing technical assistance to LGUs.

The MIS strategy requires both the DOH and local governments to play important roles in monitoring and evaluating the FP, nutrition and MCH programs. The strategy emphasizes the use of program data for decision making at the local levels, the use of provincial cluster surveys to measure FP, nutrition and MCH program performance from public, NGO, and commercial sectors, and the use of riders to NSO's Labor Force Survey and periodic demographic and health surveys to evaluate impact on the population.

Since the MIS strategy promotes the use of different, independent sources of data which are currently being funded from a variety of sources, sustainability is a serious concern being addressed by this strategy. The strategy's focus on using health service statistics for local decision making, capacity building of regional research institutions to help LGUs conduct cluster surveys, and riders added to the NSO's annual Labor Force Survey are elements of a framework intended to produce comprehensive, high-quality information at reasonable cost. LGUs, as well as the DOH particularly FPS, NS and MCHS will be vigilant about evaluating the costs and benefits of the information expected to be available and modify the data collected and methodologies as needed.

While the development and implementation of the strategy involves mainly the DOH and the NSO at the national and regional levels, the academic institutions will play an important role in providing assistance to the LGUs in the conduct of cluster surveys at the local levels.

In addition, the NGOs will participate in the preparation of the FP/ MCH/ and Nutrition Status Report through the MIS Technical Working Group. Finally, the data generated from the different elements of the strategy can be accessed by all those who are interested and have a stake in these programs.

The DOH will closely involve all donors working in FP/MCH/Nutrition programs to rationalize support to the implementation of the strategy especially in their project areas. This will avoid overlaps and encourage cost-sharing. Standardization of the MIS tool will be emphasized so that comparisons across project areas can be made at the regional and national levels and more importantly avoid confusion locally.

I. INTRODUCTION

The vision of the Philippine Family Planning Program (PFPP) is to make family planning a way of life for every man and woman of reproductive age. The program has the following goals:

- Afford women with opportunities to reduce health risks to themselves and their children;
- Provide women measures of control over their lives and bodies; and
- Provide the means to space and limit the number of children in order to help couples achieve their desired family size.

The Nutrition Program and the six programs of the MCH services - Expanded Program on Immunization (EPI), Control of Diarrheal Diseases (CDD), Control of Acute Respiratory Infection (CARI), Maternal Care Program (MCP), Under Five Care (UFC), and Breastfeeding and Weaning (BF/W) - aim to reduce death and illness among mothers, pregnant women, and children under five years of age.

To enable the Department of Health as well as the local government units provide the above services, accurate and timely data must be made available as basis in their management and implementation of these programs at their respective levels. This underscores the need for a coherent and functional management information system that will provide reliable, accurate and timely information appropriate for each level of operation.

Previous studies and assessment conducted on the existing management information systems for FP/MCH/Nutrition programs show that much is still desired to make these adequate in meeting the data needs of both the DOH and LGUs. In this regard, the DOH through the Integtrated Family Planning Maternal Health Program (IFPMHP) has decided to look once more on these existing systems and come up with a strategy on the MIS for FP/MCH/Nutrition Programs.

This document summarizes the existing opportunities and gaps surrounding the FP/MCH/Nutrition MIS of the DOH and at the LGU level. It will provide the overall vision and framework of the MIS Strategy as well as key strategies and implementation arrangements to be pursued by the DOH in operationalizing said framework.

A. BACKGROUND

During the 1970s and part of the 1980s, the DOH's FP, MCH and Nutrition Services relied heavily on information from the Health Information System (HIS), a facility-based information system that aggregates data collected from barangay health stations, health centers and other service facilities. The data collected from each reporting unit were then consolidated at the next reporting level, with

final consolidation being done by the Health Intelligence Service at central DOH, which produced an annual Health Statistics Report. Consolidated reports are submitted to the next higher unit without any validation of the data submitted or feedback given to the reporting unit which was the source of the data. The HIS was thus essentially just a system of reporting. Attempts to make it a tool for decision making proved futile as it did not provide the integrity and validity required of such a management information system.

It is for this reason that the DOH developed the FHSIS as its management information system for data on public health programs. It was conceived in response to the need for streamlining an existing reporting system that was cumbersome and fragmented. This system, initially developed with technical assistance from the World Health Organization (WHO) and subsequently from Management Sciences for Health (MSH), was extensively field tested. It begins with the maintenance of a single ledger by midwives which incorporates lists of all target beneficiaries of DOH's 12 public health programs. This book, known as the "target client list" (TCL), assists the midwife in organizing her work, identifying and following up on missed clients, and assessing her own performance in all the priority programs. FHSIS still requires the submission of reporting forms for submission and consolidation to the next higher levels, with final consolidation being done at the central office. As a facility-based system, the FHSIS is constrained by its inherent inability to provide population-based data. In addition, because of its hierarchical nature, the possibility of errors in consolidation at various levels in health system is an ever present reality. The biggest setback of the FHSIS came about in 1993 when the flow of reporting beyond the RHU level was hampered as part of an organized protest against devolution by the frontline health workers. The main effect of this boycott has been to seriously impede the DOH's already less than optimal ability to monitor programs and assess health status and program impact.

In 1996, the DOH through the Health Intelligence Service (HIS), simplified the forms into a one-page quarterly report and streamlined some of the systems of FHSIS in an effort to improve its efficiency and effectiveness and has forged an agreement with the Association of Municipal Health Officers (AMHOP) to resolve the impasse. However, the basic problems inherent in a facility-based and hierarchical information system still remain thereby limiting its usefulness at the regional and national levels. This is also compounded by the very condensed set of routinely derived program indicators which the LGUs found very limited for their needs.

While the effort to improve FHSIS is going on, the DOH-HIS has also started to advocate the use of surveys to supplement other data needs of the national and regional level. As an initial activity, HIS conducted a Basic Training Course on Surveys among regional technical staff nationwide in collaboration with the Southeast Asian Medical International Cooperation (SEAMIC). At the same time, some services in the DOH have opted to tap other sources of information for its program needs. The FPS has started to utilize data generated from the distribution of contraceptives through the Contraceptive Delivery and Logistics Management Information System (CDLMIS) which, through a method of converting the data into Couple Years of Protection (CYP), can be a good proxy for contraceptive use. Also starting in 1995, the FPS obtained national and regional estimates of contraceptive use and related data through a rider to the annual Labor Force Survey conducted by

the National Statistics Office. For their part, both MCHS and Nutrition Service conduct annual cluster surveys to assess the status of their programs. The MCH cluster surveys cover data on the various MCH programs. The nutrition cluster surveys measure the impact of the National Micronutrient Day; for 1996, the focus of the survey is on vitamin A and iodine coverage of the micronutrient supplementation program.

On the other hand, the DOH in collaboration with the National Statistics Office undertakes the National Demographic Survey (NDS) every 5 years which provides important data for planning, managing and evaluating the PFPP. The MCHS also depended to some extent on the NDS as well as the National Health Survey (NHS), which is also done every 5 years and the Safe Motherhood Survey (SMS) which was undertaken only once in 1993.

At the LGU level, the DOH has initiated the conduct of cluster surveys to measure local program performance. A number of LGUs have done cluster surveys on immunization coverage and contraceptive prevalence with assistance from the regional and central office staff of the DOH. These surveys were conducted to validate the data generated from the FHSIS and were generally accepted as the standard for measuring performance.

Also at the LGU level, the DOH has initiated efforts to utilize health and other volunteers in obtaining community-based information on program coverage. The most successful model of community-based monitoring is the masterlisting initiative of MCHS to track all children less than one year of age at the community level. This list of mothers and children is used to target immunization activities including the follow-up of clients who fail to show up during scheduled immunization rounds. Another model developed is the community-based monitoring system for family planning which was introduced in selected LGUs. The system records data on women aged 15-49 including their pregnancy-related health risks, tracks contraceptive use and non-use and facilitates the identification of cases for follow-up. Finally, under the LGU Performance Program, the DOH has provided technical assistance to LGUs in utilizing a Situational Analysis (SA) tool that assesses LGU facilities in terms of trained personnel and availability of required supplies and equipment. The data obtained from the SA provide information for the program managers to assess the service delivery capacity of LGU health facilities as well as to use the information to develop comprehensive program plans and in the allocation of LGU resources for health. In its present form, completion of the SA is still a cumbersome and difficult process, and thus will be modified to make it more responsive to LGU requirements.

B. OPPORTUNITIES AND NEEDS

As discussed in the previous section, the DOH thrives on a number of opportunities with the existence of various systems that are currently collecting and providing different sets of information important to the management and implementation of the programs. There is also indication of progress in DOH's efforts to modify existing systems and initiate new ones to meet the changing needs of the DOH and the LGUs under the devolved set-up. The availability of external funding

support for MIS-related endeavors provides a great opportunity for DOH to initiate, test and polish certain mechanisms that could then be adopted and institutionalized. This also allows the DOH more time to work out and negotiate for higher government funding for such undertakings.

At the LGU level, health program officers have begun to internalize their new roles as key managers and implementors of health programs under the devolved set-up. Some areas have initiated their own surveys and other forms of data collection to meet their specific data needs. Various tools and software have also been developed, tested and functioning in certain LGUs which are ready for dissemination and adoption by other interested LGUs. The Philippine Government has also embarked on other initiatives such the Social Reform Agenda (SRA) which requires the local government units (up to the barangay level) collect and monitor minimum basic needs (MBN) information.

While these opportunities exist, the DOH is still faced with a number of issues and gaps that need to be addressed. Foremost of these are the following:

1. The FHSIS has been modified and made more efficient, thus improving the potential of making it a more useful source of health information at the local levels. There still are a number of difficulties though that are anticipated, mainly because of its hierarchical nature and the fact that the indicators being collected were trimmed down to the barest minimum. The focus of program managers at the LGU level on FHSIS has been more on collecting and submitting said reports to the higher level. There is minimal indication that these are analyzed and used locally by the LGU program managers. There is a need therefore in the strategy to aim at maximizing the use of FHSIS at the local levels

2. Information needs are expected to vary from one level to another. There is no single source therefore that could meet their varying data requirements. Alternative mechanisms need to be explored and assessed as to their viability in providing the needed information. Some existing systems that are working could still stand further polishing to make it more adequate to meet the needs at the different levels.

    2.a At the LGU level for example, the existing SA tool developed through the LPP, the cluster surveys and some of the community-based monitoring initiatives provide the needed administrative as well as community-based information which are important tools for decision-making. The SA Guide needs further simplification and automation to make it less cumbersome for the local managers. The strategy aims to make an in-depth look at these monitoring activities with the view to institutionalizing them at appropriate levels. The DOH needs to prioritize its efforts and meager resources towards the most viable mechanisms.

    2.b. At the national and regional level, there is a need for reliable, accurate and timely population-based data to assess program effectiveness and impact. While the NSO Labor Force Survey, the National Demographic Survey (NDS) and CDLMIS provide opportunities to fill this need, current funding still relies heavily on external support.

The DOH needs to address this by working out a mechanism to institutionalize these systems.

3. It also appears that little use is made of data at the local level. Correspondingly, there still much to be desired in enabling the LGU program managers appreciate, analyze and utilize data. LGUs have limited the use of data mainly for monitoring and technical supervision. There is minimal evidence these are utilized for planning and prioritizing their resources as well as in advocating and leveraging for additional financial and logistics support from local officials and other gatekeepers. Training and other forms of technical assistance on this regard have been provided to the LGUs sporadically. Some LGUs still lack the necessary logistics support, both hardware and software to make the processing and analysis of data easier.

4. With the existence of parallel systems, overall coordination and direction is urgently needed with regard to FP/MCH/Nutrition MIS to avoid overlaps and maximize the limited resources of the DOH. The culture for sharing of tools/softwares and other information among the DOH offices, donors and cooperating agencies and across LGUs need further support and encouragement

5. Sustainability of these MIS mechanisms at the national, regional and local level confronts the DOH and the LGUs themselves. As mentioned earlier, DOH is still relying heavily on external funding support for these undertakings. This requires a more focused attention of the DOH on its overall sustainability program and to specific sustainability measures that could be done within the realm of the PFPP/MCH/Nutrition MIS program.

II. VISION, GOAL AND STRATEGIC FRAMEWORK

A. Vision

Relevant, accurate and timely information on FP, MCH and Nutrition is available to meet the data needs at the national, regional and local levels.

B. Goal

To develop the capability at the national, regional and local levels to generate and utilize relevant, accurate and timely information to improve the delivery of FP, MCH and Nutrition Services.

C. The Strategic Framework

The MIS strategy requires that both the national and local governments play important roles in monitoring and evaluating the FP, MCH and nutrition programs. The strategy emphasizes the use of program data for decision making at local levels, the use of provincial cluster surveys to measure FP, MCH and nutrition program performance from public, NGO, and commercial sectors, and the use of riders to NSO's Labor Force Survey and periodic demographic and health surveys to evaluate program impact on the population at the national level.

A strategy that makes use of a variety of data sources at different levels of the health care system may prove more viable in post devolution times. The following diagrams summarize the MIS strategy. The first diagram shows what sources of data can be used to monitor and evaluate elements of the programs from input to impact. The second diagram outlines which sources of data should be exploited at different levels of the health care system.

Diagram I.

Sources of Data for Monitoring and Evaluating Performance and Outcome

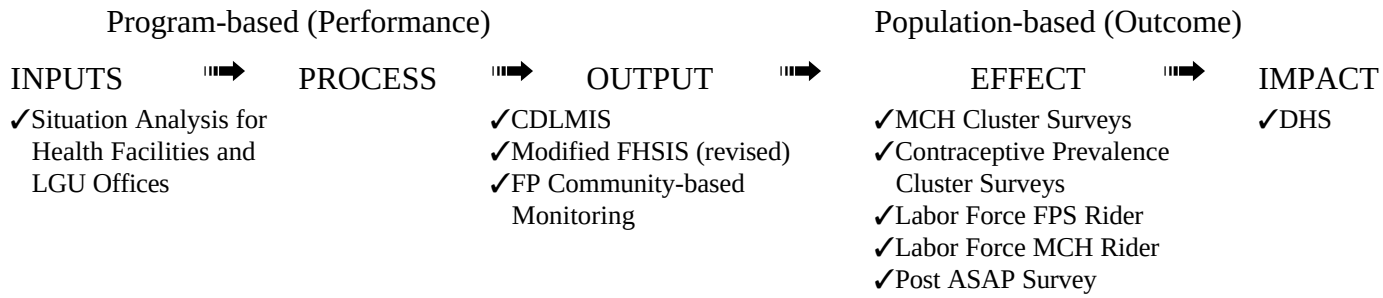

Diagram II.

Sources of Data by Levels of the Health Care System

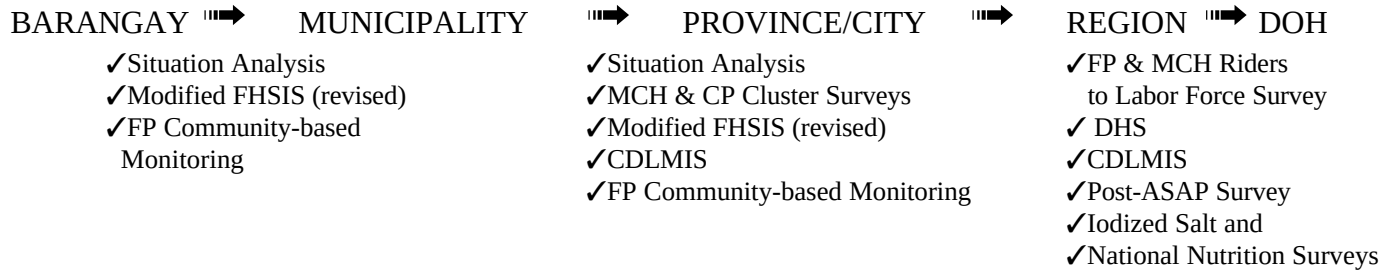

Diagram I classifies the various monitoring tools according to what they are measuring, whether program-based performance or population-based outcome. Diagram II, on the other hand, classifies the monitoring tools according to the levels they are appropriate for. Thus, at the national and regional levels, the important element would be data that measure program effect and impact, users

of whom will include not only the DOH and the national government agencies but also the NGOs, private sector and other program stakeholders. This information is best obtained through national surveys. On the other hand, program managers at the local level need data on inputs, process, outputs and to a certain extent, program effects and these information are best obtained through a combination of cluster surveys, FHSIS, and the tool which can be strengthened by an optional community-based monitoring system. As with the national level, other government agencies, NGOs and the private sector will be able to access these data.

The strategy relies on the strong support, commitment and participation of all policy makers, program managers and implementors from the barangay up to the national level. Consultations and discussions with the various stakeholders conducted in preparing this strategy revealed strong support for the strategic framework. At the national and regional levels, program managers clearly expressed a strong interest in getting program coverage information from surveys which are population-based, including cluster surveys.

At the LGU level, consultations with local health and population officials also affirmed their support in the conduct of cluster surveys based on their positive experience with such and the usefulness they will gain from this activity. Discussions with some LGU program managers also showed their appreciation of the data generated from the SA which allows them to have an inventory of the service delivery capacity of health facilities in the area. However, the tabulation and consolidation of the SA data is presently done manually and could be clearly facilitated by the use of electronic data processing techniques.

Discussions with donors and NGOs have also elicited favorable reactions. Not only did UNFPA drop the idea of a "unified" family planning MIS, it has also already planned to fund cluster surveys in two UNFPA areas in 1997 and expand coverage of the cluster surveys in 1998. The Women's Health and Safe Motherhood Project has expressed interest to cost-share an expanded MCH rider which would include more questions on maternal care. USAID has provisions to assist in the funding for the FP, MCH and Nutrition riders to the annual Labor Force Surveys in 1997 and 1999 (FP only) and in the NDS in 1998. These initial technical and financial assistance from various donors will enable the DOH to put in place a mechanism for providing or sourcing the funds that will be needed in the implementation of this strategy.

III. THE FP/MCH/NUTRITION MIS STRATEGY

The Local Government Code stipulates that the responsibility for the planning, management and provision of health services to the community now rests with the LGUs. The Department of Health retains the authority in setting standards, policies and criteria for health care of the country. These two dimensions require certain information and data which cannot be provided by a single source. The MIS program takes into account the distinct needs of the various entities involved in FP/MCH/nutrition programs: service delivery for the LGUs, monitoring and technical assistance for the DIRFOs, and standard setting, policy formulation, regulation and technical assistance for the

central DOH.

The DOH will pursue the following key strategies that would address the need of these entities for relevant, accurate and timely information as basis in carrying out their respective roles and responsibilities.

Strategy 1: ***Establish/Strengthen Appropriate Data Collection Systems at the National and Local Levels***

The establishment/strengthening of appropriate data collection systems at the national, regional and local levels is a key strategy of the MIS program for FP, MCH and Nutrition services. Such data collection systems would build on the strengths of existing MIS systems at the various levels and at the same time utilize available opportunities to ensure the generation of reliable and relevant data.

FHSIS

The FHSIS was modified in 1995 and implemented nationwide starting in 1996. The modified FHSIS produces a "minimum set of indicators" and simplifies the "flow of municipality/city health data to the national level by reducing the volume...; replacing health facility reporting by a municipality/ city consolidated reporting; reducing the frequency of the reporting...; and designing both manual and computerized data processing at the provincial level."

The DOH shall continue to pursue efforts to further streamline the FHSIS to make it more useful and relevant to the needs of the local level. One area to be explored is the possibility of the FHSIS to allow for community-based data gathering. Initial efforts in this regard have started with the on-going -collaboration between the DOH-HIS and the Makati government in installing a client-based information system. This system collects, stores and disseminates key public health data useful to the health program management and other public officials in assessing and measuring heath service delivery. The pilot-test is scheduled to start in selected barangays of the city in 1997. If this initial endeavor is viable, the system will be adopted and institutionalized throughout the city. The DOH will then use this as a model to showcase to other LGUs who would be interested in the said system through the LPP.

Another area to be pursued in redirecting FHSIS will be to maximize the use of service statistics data locally to manage services. The modified FHSIS that focuses on local levels can provide information on service utilization to assist staff to make decisions about delivery of services. FHSIS has to emphasize the local use of data in addition to consolidating and reporting data for regional and national offices of the DOH. This will provide the LGUs with some freedom to adapt systems to meet their particular needs. In the recently-modified FHSIS, output tables are complemented with the production of graphs and maps that make the presentation of data more interesting. The map is specifically designed to provide a snapshot of the health situation in a given community. Various roving teams composed of DOH-HIS staff together with their regional counterparts are now

monitoring if the LGUs are able to produce these presentations. More efforts however are still needed to develop the appreciation for and capability of the LGU program managers in analyzing data for decision-making. (See strategy 3.) The local health managers should be taught the various ways of making FHSIS data more useful. At present, the LGUs participating in the LPP are encouraged to use and analyze selected data being generated by FHSIS on FP/MCH/ Nutrition as one of the bases for planning and identifying geographical areas to be prioritized for intervention. On the other hand, the translation of service statistics into charts and graphs can be a powerful tool for presenting the LGU's accomplishments and in advocating for more resources for health. The DOH-HAMIS Project has started to develop softwares in helping LGUs analyze selected portion of the FHSIS data. Initial experiences in these innovations need to be assessed and documented. Collaboration among the program managers of the HAMIS Project, HIS and the LGU Performance Program will be done to enable wider promotion and dissemination of these tools and other MIS-related technical assistance packages that have been developed to the interested LGUs.

Lastly, wider consultations and more intensive planning and assessment will be undertaken by the DOH to determine what direction the FHSIS will take with regard to meeting information needs at the regional and national level. With the changing role of the national and regional DOH under the devolved set-up, corresponding changes are also expected in their information needs. As presented in the MIS Strategic Framework, the national and regional level would be needing data more on program effect and impact which are better collected through national surveys. Since the same DOH unit is in-charge of the FHSIS and the conduct of the national surveys in collaboration with other government institutions, redirecting DOH' efforts and prioritization of its resources on this regard will be better coordinated.

The Situation Analysis

The SA is a comprehensive planning tool used by LGUs participating in the LPP for evaluating their human and financial resources, physical facilities, equipment and supplies. The SA instrument allows the LGUs to assess the current status of their programs and prioritize their needs for assistance. The SA calls for consultations between the provincial/city level with the lower devolved units (BHS, RHU, municipal hospitals, etc.) and other organizations that are directly involved in providing services to the target populations. Information obtained from the lower devolved units are used by these LGUs as the basis for developing their annual plans. Information from lower units includes:

- a guide for municipalities, component cities, and health center;
- an inventory of provincial, district, and municipal population personnel trained in population and FP;
- an inventory of health personnel who participated in FP courses;
- an inventory of health personnel who participated in CS courses;
- an inventory of PHO/CHO staff who participated in FP courses;
- an inventory of PHO/CHO staff who participated in CS courses;
- an inventory of essential commodities, supplies, and equipment for FP services;
- an inventory of essential commodities, supplies, and equipment for CS services;
- an inventory of essential commodities, supplies, and equipment for VSS services;

- an inventory of health facilities providing FP services;
- an assessment of program coverage based on selected CS indicators by municipality, component city, and health center;
- an inventory of health facilities providing CS services; and
- an inventory of program management equipment.

The strategy will make the SA tool less cumbersome and time-consuming to complete by simplifying the form, and developing a computer software that will quantify the data collected. At the same time, LGU capability building will be centered on the analysis of data obtained from the SA, not on its consolidation.

Community-based monitoring

Community-based monitoring involves the comprehensive masterlisting of the target clientele at the barangay level by volunteer health workers. The MCH program has demonstrated through the EPI masterlisting initiative how community-based information can enhance program performance. In the EPI model, Barangay Health Workers and other volunteers assist the health care providers in generating a complete and comprehensive list of clients (in the case of EPI-children under one year of age) eligible for immunization. The health worker with the help of the volunteers use this information to target and inform clients about immunization schedules and track down those who fail to show up during immunization rounds. Another community-based monitoring initiative was the system introduced in selected LGUs through the assistance of Family Planning Management Development project of MSH where population program volunteers were encouraged to list married women of reproductive ages, their age and health risk characteristics. The system also allows the health worker and the volunteers to track contraceptive use and non-use and prioritize cases for follow-up.

From these models, it can be seen that community-based monitoring can be a powerful tool for enhancing program performance. Community based monitoring will enhance the focus and validity of data obtained from the SA, FHSIS and the cluster surveys and will provide community specific data that will enable particular LGUs to institute LGU-specific measures to improve program planning and implementation. The DOH will provide technical assistance to LGUs which will opt to use this tool as part of their management information system.

Cluster surveys

Because of its simple design and execution, cluster survey offers program managers with a cost-effective tool to obtain reliable and accurate information at a fraction of the cost of traditional multi-stage surveys. This strategy will encourage particularly the LPP LGUs to conduct family planning multi-indicator surveys to complement FHSIS data.

The DOH and many LGUs have previous experience in planning and conducting cluster surveys. Most LGUs conducted EPI cluster surveys between 1990 and 1992. The DOH carried out

contraceptive prevalence cluster surveys in six selected provinces in 1991 and in another 30 in 1993. In 1994, a national, integrated MCH cluster survey was conducted to estimate immunization coverage, ORT use, ARI management, maternal care and breastfeeding, iron supplementation, and contraceptive prevalence. In 1995, a few LGUs conducted contraceptive prevalence surveys. International assistance and research institutions have played various roles in the planning and conduct of these surveys.

The 47 LGUs participating in the LPP to date were asked to complete a questionnaire on their experience with cluster surveys. Of the 27 LGUs that reported, 21 have conducted cluster surveys: 13 have conducted EPI cluster surveys, five have conducted contraceptive prevalence cluster surveys, and three have carried out multi-indicator MCH cluster surveys. Most of the 27 LGUs participated in data collection while six or seven actually participated in data processing and analysis. Ten reported having difficulty locating households and conducting interviews, four had difficulty in processing and analyzing the data, and five said that securing funding was difficult.

Eighteen of these LGUs want to share responsibility for conducting cluster surveys with research institutions. Nearly all LGUs responded that they can play a major role in training interviewers and in collecting the data, but will need assistance to plan and design the surveys and analyze the data. The LGUs will be assisted by academic research institutions in the planning and conduct of these cluster surveys.

A short term target of this strategy is to rework the design of existing cluster surveys being used in the Philippines by the DOH and the LGUs. These surveys will be assessed and adapted to meet the requirements of FP/MCH/Nutrition programs. This will be particularly crucial for the 47 LGUs participating in the LPP, whose 1997 benchmarks include conducting cluster surveys and reporting on contraceptive prevalence (percent of women of reproductive age who are currently using program or non-program FP methods), immunization (percent of living children between 12-23 months who have been vaccinated before their first birthday against BCG, DPT, polio and measles), tetanus toxoid (percent of pregnant women and mothers of reproductive age with children under five who have received at least two doses of tetanus toxoid), and vitamin A coverage.

DOH will coordinate with donors regarding their participation in and support to the planning and implementation of the multi-indicator cluster surveys.

CDLMIS

The CDLMIS is a nationwide contraceptive logistics system which reports data on contraceptive stocks, utilization and needs at the LGU level and at over 3,700 contraceptive delivery points. Managed by the DOH/FPS with technical assistance from the Family Planning Logistics Management project of John Snow, Inc., the CDLMIS has 148 contraceptive delivery teams nationwide which function as the reporting units of the system. These teams collect data from all the contraceptive delivery points when they do their quarterly delivery runs. The data collected are then sent directly to DOH/FPS for encoding and analysis.

At both LGU and national levels, CDLMIS data are useful not only in showing availability of contraceptives, they also provide data on Couple Years of Protection (CYP). The CYP as generated through the CDLMIS is a good proxy indicator for contraceptive use and will continue to be collected and analyzed. CDLMIS will be strengthened to generate information that will lead to an accurate estimation of CYPs. The regional DOH staff will be trained and provided with management support to sustain CDLMIS implementation.

National Surveys

Apart from the CDLMIS, alternative data-collection mechanisms at the national level will include the various national levels, such as the riders to the National Labor Force Survey, the National Demographic Survey, other surveys such as Vitamin A coverage and iodized salt surveys.

The NSO, in collaboration with the HIS of the DOH, conducts a National Health Survey (NHS) scheduled every five years. The most recent one was in 1992. The NSO also conducts a National Demographic Survey (NDS) every five years in collaboration with Macro International. The NDS is one of the demographic and health surveys funded worldwide by USAID. The last NDS in the Philippines was in 1993. The NSO is also authorized to conduct a census every decade, and sometimes every five years. In addition, the NSO conducts a FP survey as a rider to its Labor Force Survey each year, the most recent having been completed in July 1996. The NSO is prepared to add an MCH rider to its Labor Force Survey beginning in April 1997. The information from these surveys on the status of the population at risk is essential to the DOH and donors for national programming. FP, MCH and Nutrition riders to the NSO's Labor Force Survey are more cost-effective than stand-alone surveys for evaluating national FP, MCH and Nutrition program performances.

The strategy will work towards the institutionalization of these mechanisms at the DOH by gradually and progressively absorbing the costs of such surveys, which heretofore have been funded by foreign donors. The strategy will also look into the possible integration of the NDS and the NHS with regard to FP/MCH/Nutrition.

Strategy 2: ***Increase awareness, appreciation and capability of key LGU officials and program managers on FP/MCH/Nutrition MIS***

While the DOH moves towards institutionalizing alternative information sources for FP/MCH/Nutrition Programs at both the national and local level, it shall also develop and implement measures to improve the awareness, appreciation and capability of the LGU officials and program managers on data need identification, analysis, dissemination and utilization.

In general, it has been observed that most LGUs are still limited in terms of appreciation and capacity to use and analyze data for program management and implementation. As experienced in the FHSIS, the LGUs were more focused towards gathering and collecting data rather than analyzing and using

these to address program needs. Though most of the LGUs claim to use these information in their monitoring and technical supervision, there is very little evidence of these data being used for other purposes such as mobilizing and negotiating higher allocation of resources for their programs. The LGUs participating in the LPP have undergone exercises in data analysis as part of accomplishing the SA portion of their annual plans. It is observed that most of the LGUs would really need more formal training and skills development in data analysis and interpretation. Some LGUs even signify the need for technical assistance on more basic concerns such as identifying the right indicators to collect to manage their programs. On the other hand, initial consultations done with selected LGUs regarding the cluster surveys indicated that most of them would need help from research institutions on all stages of the survey from the design to analysis and dissemination.

The DOH shall undertake a more thorough assessment of the existing capabilities and needs of selected LGUs with regard to data management. Current training courses being offered by POPCOM and DOH on this regard shall be reviewed if these meet the requirements of the LGUs and have to be upgraded, if needed. A package of training assistance will be offered to the LGUs through the LPP. Funding for these could be taken by the LGUs from their LPP grant and supported from any additional appropriation that would be generated from the HES initiative.

Building the LGUs' capability may come in various forms aside from training. At present, there are different cooperating agencies under the IFPMHP which provide technical assistance to the LGUs on certain aspects of MIS. For one, the DOH-FPS, with assistance from the Population Council, has already trained a number of LGU program managers on operations research (OR) which tackled basic principles on survey design, tools development, data enumeration/collection, analysis and dissemination. What has also been emphasized in these OR workshops is the need for these program managers to think OR and use the OR approach in addressing their problems in their program implementation. The IFPMHP-IEC subcomponent also plans to develop generic KAP survey tools for the use of LGUs in measuring progress in their IEC efforts. This serves another opportunity to develop the LGUs' capability on this concern. Through the conduct of the cluster surveys under the IFPMHP-Program Monitoring subcomponent, the importance of collecting accurate and timely data will be reiterated and LGUs will learn to appreciate and manage these surveys at their level. Through the LPP, the DOH will continue to develop the skills of the LGU program managers in analyzing selected data as basis for developing their annual plans and in prioritizing allocation of their resources. There is a need therefore to strengthen the coordination among these cooperating agencies involved and other DOH units concerned in order to come up with a more coherent package of technical assistance to the LGUs on this regard.

While training may address skills development among the LGU Program Managers, there is a more basic need to reorient them regarding their perspectives towards data collection and utilization. With their new role as managers and implementors of health programs, the LGUs must learn to appreciate the need to collect data accurately and timely and use these maximally for their own benefits. LGU staff should not just be concerned with collecting data for submission to higher levels but to analyze and use these as basis for improving their programs. LGUs must also be taught on how the data they are collecting can become powerful tools in leveraging more support for their programs. Under the IFPMHP-Advocacy subcomponent, DOH and POPCOM plan to develop the advocacy skills of the LGU program managers using available data. This will be a good opportunity for the LGUs to learn how data can be treated and maximized for other purposes aside for monitoring and technical

supervision.

In support to these capability-building opportunities, the DOH shall also ensure that the LGUs are equipped with the necessary tools, both software and hardware. Through the LPP, all participating LGUs have already acquired computers to support their data management requirements in addition to what they obtained from other projects of assistance and local appropriation. What is needed is to provide them with a software that would facilitate their analysis and interpretation.

At the national level, there should be a continuous reorientation of the perspectives among program managers and other stakeholders with regard to the appropriate data or information the national and regional level need, and, more specifically, on how these could be collected more accurately and efficiently.

Strategy 3: ***Enhance and maximize the use of data for program planning, management and implementation***

Among the most common problems in relation to data is not that there is lack of them but that they are not utilized and disseminated widely enough. The strategy will thus enhance and maximize data utilization and dissemination.

At both national and local levels, program managers will be trained to appreciate the usefulness of data for program planning, updating technical knowledge, advocacy, and social mobilization. Local-level program managers will need to advocate the importance of the various programs to their Local Chief Executives through the use of research-based data. Convincing their local legislative councils will require the local program managers to use such data. Mobilizing community support for their programs will be possible only if the program managers use valid and reliable data and present them convincingly.

The capability of national program managers in data dissemination and utilization will be strengthened. The strategy will institutionalize within the DOH the development of the annual FP/MCH/nutrition status report. This report, which is one of the most important forms of data utilization, is aimed at helping the DOH monitor the progress of these programs toward increasing contraceptive prevalence, slowing the national population growth rate, and improving maternal and child survival. This report is useful for the DOH in its internal program management purposes (where is progress being made, where are greater efforts needed) as well as for external reporting by the DOH (making a case for and defending its annual budget). The report utilizes the information generated through this MIS program especially at the national level but may also include relevant and appropriate information generated by the LGUs for consistency checking and validation. The Status Report for the previous year shall be completed by June and disseminated shortly thereafter. This report, which will make use of the data generated through the various data-collection mechanisms, will be used as an information and advocacy tool by the DOH to be disseminated to various national agencies, and to executive and legislative leaders.

The strategy will ensure that the head of the MIS section of FPS takes the lead in preparing this

report supported by a Technical Working Group composed of representatives from the MCH Service, the Nutrition Service, the Health Intelligence Service, a representative from the NGO sector and others as determined by the Office for Public Health Services.

Strategy 4: ***Institute mechanisms to ensure availability of resources, particularly funding support, for MIS-related activities at the national and local levels***

An effective MIS is one that is sustained in the long haul to allow for institutionalization, comparative analysis over time and the development of standard planning parameters. Sustainability of MIS activities is therefore a key strategy.

In the initial years of implementation of this MIS Strategy, funding of the various MIS activities is assured as both the DOH and the LGUs are expected to fund the conduct of cluster surveys and the other elements of the strategy at the local level through the LPP, donor grants, the IRA and other sources available to the LGUs. At the national level, the 1997 and 1999 FP riders to the Labor Force Surveys and the 1998 NDS will be funded with assistance from USAID.

Through a program sustainability initiative which is a major part of the strategy, the DOH will take the lead in maintaining the MIS program from the regular DOH budget. Apart from lobbying for bigger MIS allocation from their respective budgets, the FP, MCH and Nutrition Services will also support increased MIS budgets from the other services of DOH.

At the local level, funding for MIS can be sourced out from the regular budget of the LGU health and population offices. Funding may also come from the social development fund, particularly that portion intended for the Human and Ecological Security (HES) initiative. LGU program managers would also be encouraged to include the MIS component in their budgetary proposals. As in the national level, it is necessary to advocate for increased allocations for MIS and research in addition to one's own program. Very few LGUs allocate substantial amounts for MIS and research at this time, because of their primary mandate of service delivery. However, with advocacy, and with the help of the local health board, local health executives may be able to justify increased allocations for MIS and research. It is also important to "piggyback" FP/MCH/Nutrition MIS activities with other activities, which have their own funding. For instance, community-based monitoring is not really a stand-alone MIS activity. It is often part of a community-participation/social mobilization effort. As such, the activity need not be allocated a separate budget as an MIS activity. Another example, report collection, one of the bottlenecks of the FHSIS, could be done during monitoring visits or logistics delivery runs as long as these are regular.

Strategy 5: ***Coordinate efforts on FP/MCH/Nutrition MIS-related concerns at the national level***s

The FP, MCH and Nutrition Programs are mostly inter-agency, intersectoral efforts with the DOH serving as coordinator. It follows that the MIS efforts of these programs should also be coordinated for the following reasons:

- to minimize overlaps in efforts. Service providers are overburdened with many reports required of them. It would give them more time to provide service if the number and frequency of reports, especially those asking for the same data, would be minimized.

  Organizations, could share data with one another instead of asking from the service providers over and over again. At the same time, surveys may also be integrated to some extent to minimize cost.

- to standardize definitions, mechanics and schedules, whenever possible. MIS data, when consolidated, can be accurate only if the reporting units follow the same standard definitions, mechanics and reporting periods.

- to address issues and operational problems. As with all systems, there is need for constant review and revision, debugging and problem-solving.

- to share resources such as tools, hardware or equipment and manpower. Reporting formats could be integrated, computers shared, common survey questionnaires used and manpower utilization maximized.

MIS coordination will cover different services/programs, agencies and sectors:

1. DOH services and program offices, including those in charge of the three programs concerned and related programs such as those concerned with reproductive health concerns and child survival services, the USAID-assisted IFPMHP, the Women's Health, Safe Motherhood Project (WHSMP), the UNFPA and UNICEF-assisted country programs, Urban Health and Nutrition Project (UHNP), FAMUS and the Essential National Health Research Network (ENHR) and those involved in DOH-MIS efforts such as the HIS, MAS and HAMIS Project.

2. Partner agencies in each program including non-government organizations (NGOs) and civic organizations, other government agencies whose network of service providers work with the government health network to bring services to those who need them and whose performance should be reflected in the overall program performance for a more accurate picture.

3. National government agencies with similar or parallel efforts such as the Social Reform Agenda/Minimum Basic Needs (SRA/MBN) program initiatives of the President which require community profiles including health indicators.

4. Donor agencies, which require assisted project reports on specific indicators and assist other MIS efforts.

5. Academic institutions, especially those which conduct studies on program impact and provide technical expertise along this line.

6. The commercial sector, which would allow program managers a look into the status of the section of the population who go to private practitioners and whose performance in the market would impact on the government's capacity to meet the needs of the total population.

At the national level, it is the DOH and the NSO that are primarily involved in the implementation of the strategy. At the local level, academic research institutions play an important role in providing assistance to the LGUs in the conduct of cluster surveys. Thus, the strategy will utilize the expertise of research institutions which have been involved in the research activities of the ENHR and in the OR studies of the Population Council.

The NGOs, for their part, participate in the preparation of the annual FP/MCH/Nutrition status report. In addition, their service delivery performance is another source of data for the calculation of the CYP.

As the PFPP begins to more actively involve the commercial private sector, as mandated by the new PFPP Strategy, the DOH will address the issue of how best to capture the private sector contribution to the program through its alternative data collection mechanisms.

Even as the DOH works towards absorption of MIS costs, it will encourage donors to support the implementation of the strategy particularly in their project areas.

IV. IMPLEMENTATION ARRANGEMENTS

A. Roles and Responsibilities

The Department of Health

As the lead agency for the PFPP, the DOH will manage the MIS program. Different DOH units will continue to be responsible for the implementation of their respective elements of the MIS strategy. HIS will continue to make FHSIS relevant particularly to the LGUs. FPS will take the lead in working with the NSO for the conduct of the NDS and the FP rider surveys. MCHS will be responsible for special national surveys on child survival and maternal health. NS will ensure the conduct of special nutrition surveys.

A Technical Work Group on MIS will be constituted, composed of representatives from the above-mentioned DOH services and other units concerned with MIS and the collection and management information. Representatives of related projects and from the NGO/private sector will also be invited to join the TWG. The TWG will be responsible for coordinating the MIS related activities of the FP, MCH and Nutrition Services. Other functions of the TWG are:

- Serve as a forum for discussing cross cutting MIS related issues and problems;
- Provide technical oversight to the implementation of the MIS program;
- Prepare technical/policy recommendations on the MIS program to management;
- Provide technical guidance and direction to the production of the Annual FP, MCH and Nutrition Status Report.

The DOH will work towards the absorption of the cost of such surveys.

The LGUs

They will be responsible for the implementation of the following data-collection mechanisms: the modified FHSIS, cluster surveys, community-based monitoring, SA and CDLMIS.

They will make available financial and manpower resources to make the above-mechanisms work.

They will ensure the proper dissemination and utilization of the data collected to improve and sustain program operations.

B. Review and Refinement of Existing Data-Collection Mechanisms

The FHSIS was simplified in 1995 but feedback from LPP LGUs shows that, in fact, they much prefer the earlier forms because they yielded more data useful to the LGUs. HIS will review the FHSIS with the view to making the data collected more relevant and useful to the LGUs. At the same time, HIS will see as its mandate the development of tools and broadening the FHSIS from facility-based into a community-based system will be pilot-tested in 1997.

The SA tool being used by the LPP LGUs has been found to be cumbersome and time-consuming to complete. The DOH will review the existing SA forms with the view to making them more quantifiable. An application software will be developed through technical assistance from an MIS specialist which would facilitate the consolidation of the SA data into user-friendly tables and graphs. The software application will then be introduced to the LPP LGUs and become part of their management systems.

The existing community-based monitoring models will be reviewed by the TWG to determine the possibility of integrating the various FP/MCH/Nutrition indicators in one model. An appropriate model will be recommended. Guidelines on the application of the selected community-based model will be developed and introduced to interested LPP LGUs for pilot-testing.

The CLDMIS database will be further refined. The FPS will look into the existing classifications to avoid misclassification of public and private contraceptive delivery outlets.
The design of existing cluster surveys will be reviewed by the TWG and adapted to meet the requirements of the FP/MCH/Nutrition programs and the LGUs. The TWG will undertake this task in time for the LGUs to finish the conduct of the cluster surveys by September 1997.

The annual FP rider survey to the NSO Labor Force Survey will be broadened to include MCH concerns for the 1997 survey. The rider survey will be included in the April 1997 LFS. The TWG will work with the NSO in the design of the questionnaire, the training of the enumerators and the dissemination of the research results.

C. Conduct of National and LGU Cluster Surveys

In the pipeline are the following national surveys: the 1997 FP/MCH Rider to the April 997 Labor

Force Survey (discussed in the preceding section), the 1998 Demographic and Health Survey (DHS) and the 1999 rider survey. They will be conducted by the NSO. Funding will come from USAID for the 1997, 1998, and FP portion of the 1999 surveys.

The 1998 DHS is a follow-on to the survey conducted in 1993, which is more popularly known in the country as the NDS but which is in fact, the Philippine version of similar DHS surveys conducted world-wide by Macro International. As in the 1993 study, the 1998 DHS will collect data not just on fertility and family planning but also on infant and child mortality, maternal and child health, infant feeding and supplementation, maternal mortality and health services utilization.

The 1999 rider survey will again include FP/MCH and nutrition indicators. As USAID funding commitment is only for the family planning component, DOH will provide funding for the two other components of the rider survey.

At the local level, multi-indicator cluster surveys will be conducted in 1997 by all LGUs participating in the LPP. The LGUs will be assisted by locally-based academic research institutions, which will be identified and selected by them with assistance from the DOH. For 1998 and beyond, the LPP LGUs will be encouraged to continue funding the conduct of these cluster surveys for them to determine the impact of their own family planning and MCH interventions.

D. Training Requirements

The TWG will oversee the design and implementation of a training program to improve the information management skills of program managers at the local, regional and national levels. Such training would utilize existing information on the training needs of program managers and would likely cover such areas as appreciation of quality data, data collection methods, data analysis and interpretation, report writing, data dissemination and utilization.

LGU resources will be tapped for the conduct of training while DOH resources will be used for training its program managers.

E. Data Dissemination and Utilization

Training will enhance the capacity of program managers at both local and national levels to disseminate and utilize research data.

Technical assistance on research dissemination and utilization will be provided by the Population Council to the TWG.

Presentation of completed research studies on FP/MCH/Nutrition through research dissemination workshops will be institutionalized.

Other modes of research dissemination will be explored by the TWG.

The production of the annual status report on the FP/MCH/Nutrition programs will be the core data dissemination activity of the TWG.

At the local level, the advocacy project of POPCOM will assist in improving the skills of LGU program managers to advocate for their programs through the use of research-based data and information.

F. Resource Generation and Planning for MIS Sustainability

It is the intention of the MIS strategy to make these various MIS activities more sustainable and less donor-dependent. Therefore, the DOH will develop an MIS sustainability plan in 1997.

The FP, MCH and Nutrition Services will propose a bigger share for MIS activities in their respective budgets starting in 1998.

Advocacy will be done by both the DOH and POPCOM (as part of its advocacy project with the Futures Group) to make LGU officials appreciate the importance of research-based data for policy development, program planning, and implementation of their various programs. At the local level, funding can come from at least tree sources: the regular budget of the health office; the regular budget of the population office; and a special allocation from social development fund intended for HES activities, under which MIS activities at the local level will fall.

G. Coordination Arrangements

The TWG will serve as the coordinating body for MIS-related technical concerns and issues. The FP, MCH and Nutrition services will also continue consultations, meetings and roundtable discussions with concerned agencies on matters that would impact on MIS.

A number of Cooperating Agencies (CA) under the IFPMHP have been providing technical assistance and will continue to do so in MIS--related areas. These include the following:

- the Population Council, which plans to develop the capacity of at least 30 LPP LGUs to manage and utilize OR studies on service delivery issues by 1999;

- the John Hopkins University/Population Communication Services, which intends to develop KAP tools for use by the LGUs in measuring the progress of their IEC efforts;

- the Futures Group, which has assisted POPCOM to improve the population and development advocacy program, with the view to, among other things, persuade the LGUs to provide greater support, including budgetary allocation, for the PFPP, including MIS activities;

- the Family Planning Logistics Management Project of John Snow, Inc., which has conducted training at national and regional levels towards full management by the government of CDLMIS;

- the Management Sciences for Health, which has provided technical assistance in the development of the MIS strategy and for the yearly FP/MCH/Nutrition status reports; and

- MACRO International for the conduct of the 1998 NDS and its secondary analysis.

The unique expertise of these CAs will continue to be tapped by the DOH in implementing the MIS Strategy.

V. TIMELINE FOR MIS STRATEGY

Activities																	
		1997				**1998**				**1999**				**2000**			
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1. FP, MCH Rider to the Labor Force Survey																	
a. Finalization of MCH Questionnaire	x																
b. Conduct of Survey			x								x				x		
c. Submit Report				x								x				x	
d. Prepare FP, MCH & Nutrition Status Report																	
Activities																	
		1997				**1998**				**1999**				**2000**			
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2. LGU Cluster Surveys																	
a. Finalize Questionnaire and Handbook	x																
b. Train LGUS and Academic Institutions		x															
c. Conduct Surveys			x	x			x	x			x	x			x	x	

d. Submit Report				x				x				x				x	
3. SA Tool																	
a. Streamline SA Form	x																
b. Develop Application Software		x															
c. Introduce to LGUs			x	x	x		x	x			x	x			x	x	
4. Other Elements FHSIS and Community-based Monitoring																	
a. Develop Guidelines		x															
b. Introduce to Interested LGUs			x	x			x	x				x	x		x	x	
B. Training and Capability Building																	
a. Needs Assessment		x	x														
b. Design of training program			x	x	x												
c. Implementation						x	x			x	x			x	x		
C. Sustainability Measure																	
a. Develop sustainability plan			x														

Activities																	
		1997				**1998**				**1999**				**2000**			
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
b. Implementation * Budgetary preparation and submission				x				x				x				x	
* Advocacy				x				x				x				x	
D. Coordination Measures																	
a. TWG meetings	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
b. Inter-project meetings	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

VI. RESOURCES REQUIRED FOR THE MIS STRATEGY

Although the MIS Strategy promotes the use of different, independent sources of data from a variety of funding sources, sustainability is likely to be a serious concern. The LGUs are expected to fund the conduct of cluster surveys and the other elements of the strategy at the local level out of the local resources including the LPP grant, grants from other donors, local GOP funds and other sources available to the LGU. At the national level, the 1996 surveys and the 1998 NDS will be funded through assistance from USAID while in 1999, the DOH is expected to cost-share the conduct of the FP, MCH and Nutrition Cluster surveys.

Below is an illustrative budget of the MIS program for the period 1997-2000.

MIS Element		1997	1998	1999	2000	Total: All Yrs.	Funding Source
1.	Cluster Surveys	7.00.M	9.75 M	12.75 M	15.00 M	44.50 M	LGUs, Other sources
2.	FP, MCH and Nutrition Rider to the Labor Force Survey	7.5 0M	(no rider because of NDS)	8.00 M	10.00 M	25.50 M	USAID for 1997,1998, 1999 & DOH in 1999 & 2000
3.	Other elements (FHSIS, SA, Community-based Monitoring)	_	_	_	-	-	
4.	DHS Survey (NDS) and Secondary Analysis	-	18.20 M	-	-	-	USAID
	Total	**14.50 M**	**27.95M**	**20.75M**	**25.00 M**	**70.00 M**	

At the national level, possible sources of funds would include the regular DOH budget and from external assistance. The Family Planning, MCH and Nutrition Services will ensure that the services' budgetary proposals will include provisions for the MIS component.

At the LGU level, funding for the MIS can be sourced out from the regular budget of the LGU health and population offices. It can also be taken out of the 20% development fund, specifically that portion of intended for the HES initiative. LGU program managers would also be encouraged to include the MIS component in their budgetary proposals.

In early 1997, the DOH together with the LGUs, will develop a scheme for financing the cost of maintaining the MIS Program.

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Annex 1

Table of Research Institutions and LPP-Participating LGUs by Region

Regions	Research Institutions	LGUs in the LPP to date
CAR	1. Center for Cordillera Studies (CAR)	1. Baguio City 2. Benguet
I	1. Institute for Development Alternatives (IDA) 2. Pangasinan State University 3. University of Northern Philippines	1. Pangasinan 2. La Union 3. Ilocos Sur
II	1. Cagayan State University 2. Nueva Vizcaya State Institute of Technology 3. Isabela State University 4. Cagayan Colleges 5. Center for Cordillera Studies 6. St. Paul University	1. Isabela 2. Cagayan
III	1. Central Luzon State University 2. Center for Central Luzon Studies 3. Central Luzon Polytechnic College 4. Pampanga Agricultural College 5. Tarlac State University 6. Western Luzon Agricultural College 7. Manuel S. Enverga University Foundation 8. Wesleyan University-Philippines	1. Bulacan 2. Pampanga 3. Nueva Ecija 4. Tarlac 5. Bataan
IV	1. University of the Philippines, Los Baños 2. Don Severino Agricultural College	1. Batangas 2. Cavite 3. Palawan
V	1. Ateneo de Naga University, Social Science Research Center 2. Ago Medical & Educational Center, Bicol Christian College of Medicine	1. Albay 2. Masbate
VI	1. West Negros College 2. Concerned Council for the Enhancement of Resources and Networking Systems (CONCERNS, Inc.) 3. Central Philippine University 4. University of Negros Occidental Recoletos, Research and Development Center 5. University of St. La Salle 6. Colegio de San Agustin, Bacolod 7. Riverside College 8. West Visayas State University 9. University of San Agustin 10. University of Iloilo, Center for Research and Development	1. Iloilo City 2. Iloilo 3. Bacolod City 4. Negros Occidental 5. Capiz

Regions	Research Institutions	LGUs in the LPP to date
VII	1. U.P. Cebu College 2. Silliman University, Social Science Research Center 3. Divine Word of Tagbilaran 4. University of San Carlos	1. Cebu City 2. Cebu 3. Bohol 4. Negros Oriental
VIII	1. Samar State Polytechnic College 2. Divine Word University of Tacloban 3. University of the Philippines, School of Health Sciences 4. University of the Philippines, Tacloban College 5. Remedios Trinidad Romualdez Medical Foundation College of Nursing 6. University of Eastern Philippines 7. Eastern Samar State College 8. Naval Institute of Technology 9. Leyte Institute of Technology 10. Visayas State College of Agriculture (VISCA)	1. Leyte
IX	1. Western Mindanao State University 2. Ateneo de Zamboanga University 3. Countryside Research and Development Foundation, Inc. 4. Southern Mindanao Colleges 5. Andres Bonifacio College 6. Sulu State College	1. Zamboanga City 2. Zamboanga del Sur
X	1. Xavier University, Research Institute for Mindanao Culture 2. San Nicolas College, Surigao Research and Development Training Center Foundation, Inc. (SRDTC) 3. Urios College 4. Central Mindanao University 5. Bukidnon State College 6. Andres Bonifacio College 7. Center for Educational and Social Research, Cagayan de Oro College 8. Bukidnon State College 9. Mindanao Polytechnic State College 10. Misamis University	1. Cagayan de Oro City 2. Bukidnon 3. Misamis Oriental 4. Misamis Occidental
CARAGA		1. Surigao del Sur 2. Surigao del Norte
XI	1. Ateneo de Davao University 2. Cor Jesu College 3. Center for Education, Research and Development in Health-Davao Medical School Foundation (MSF-CERDH) 4. Southern Mindanao College	1. Davao City 2. Davao del Norte 3. South Cotabato 4. Davao del Sur 5. Davao Oriental

Regions	Research Institutions	LGUs in the LPP to date
XII	1. Gowing Memorial Research Center of Dansalan College Foundation, Inc. 2. Notre Dame University of Midsayap College 3. MSU-Iligan Institute of Technology 4. Mindanao State University, Marawi 5. Notre Dame of Tacurong College 6. Notre Dame of Marbel University 7. Sulu State College 8. Notre Dame University, Cotabato City	1. Cotabato
ARMM		1. Maguindanao
NCR	1. HEWSPECS, Inc. (Health, Education & Welfare Specialists 2. ER Associates, Inc. 3. Institute of Philippine Culture, Ateneo de Manila University 4. Center for Community Services (Health Services Unit: Health Alternative for Total Human Development, HEALTHDEV, Inc.) 5. Organization for Public Health Education 6. College of Public Health, University of the Philippines 7. U.P. Department of Psychology (Diliman) 8. Institute for Social Studies and Action (ISSA) 9. KABALIKAT ng Pamilyang Pilipino Foundation, Inc. 10. College of Public Administration, U.P. 11. De La Salle University, University Research Coordination Office	1. Quezon City 2. Pasay City 3. Muntinlupa 4. Malabon 5. Pasig City
Totals	**80 Reserach Institutions**	**47 LGUs**

ANNEX 2
Sample MCH Rider Survey Questionnaire

CONFIDENTIALITY: All information obtained about any individual respondent will be held strictly confidential.

1997 MATERNAL AND CHILD HEALTH RIDER SURVEY

PROV..... ☐☐

MUN..... ☐☐

BGY..... ☐☐☐☐

HCN..... ☐☐☐☐

LN..... ☐☐

Name of Eligible Woman:

Self-administered?
1. SAQ
2. Personal interview

Reason for non-response:
1. Refused
2. Respondent not around/not available
3. Household not around/moved out
4. Others
(specify)_____

NO	QUESTIONS	CODING CATEGORIES	SKIP TO
1	Do you have any children under the age of five?	Yes..... .. 1 No..... .. 2	→ END
2	When you were pregnant with (NAME OF YOUNGEST CHILD), did you see anyone for prenatal care for this pregnancy? If YES, whom did you see? Anyone else? RECORD ALL PERSONS SEEN.	HEALTH PROFESSIONAL Doctor..... .. 1 Nurse..... . 2 Midwife..... . 3 OTHER PERSON Trained Hilot..... 4 Untrained Hilot..... 5 Other..... . 6 No One..... 7	→SKIP TO Q4
3.	How many prenatal visits did you have during this pregnancy?	No. of visits..... □□ DK.....98	
4.	When you were pregnant with (NAME OF YOUNGEST CHILD), were you given any of the following? Iron tablet/capsule? Iodine capsule? Tetanus toxoid, an injection to prevent the baby from getting tetanus, that is, convulsions after birth?	YES NO DK Iron tab/cap.....1 2 8 Iodine cap.....1 2 8 Tetanus toxoid.....1 2 8	2 or 8 →SKIP TO Q6
5.	During this pregnancy how many times did you get tetanus toxoid injection?	No. of times □ DK..... .. 8	

6.	Did you receive any tetanus toxoid injections at any time before your pregnancy with (NAME OF YOUNGEST CHILD)?	Yes..... 1 No..... 2 DK.....8	2 or 8 →SKIP TO Q9
7.	How many times did you receive the tetaus toxoid injection?	No. of times ☐ DK..... 8	
8.	Of the tetanus toxoid shots you reported in Q7, when was the last shot received? RECORD MONTH AND YEAR OR THE NUMBER OF YEARS AGO.	MM/YY .....1 ☐☐ ☐☐ OR YEARS AGO .....2 ☐☐	
9.	Did you see anyone for postnatal check-up after the birth of (NAME OF YOUNGEST CHILD)? If YES, whom did you see? Anyone else? RECORD ALL PERSONS SEEN.	HEALTH PROFESSIONAL Doctor..... 1 Nurse..... 2 Midwife..... 3 OTHER PERSON Trained Hilot..... 4 Untrained Hilot..... 5 Other..... 6 No One..... 7	→SKIP TO Q11
10.	What services did you receive during your postnatal check-up? RECORD ALL SERVICES RECEIVED.	Check-up of baby..... 1 Check-up of mother..... 2 Instructions on breastfeeding, formula feeding..... 3 Family planning advice/service.....4 Other_____ 5 (Specify)	

11.	Did you ever breastfeed (NAME OF YOUNGEST CHILD)?	Yes..... .. 1 No..... .. 2	→SKIP TO Q13
12.	Why did you not breastfeed (NAME OF YOUNGEST CHILD)?	Mother ill/weak..... 1 Child ill/weak..... 2 Child died..... 3 Nipple/breast problem..... 4 Insufficient milk..... 5 Mother working..... 6 Child refused..... 7 Other_____ 8 (Specify)	
13.	For how many months did you breastfeed (NAME OF YOUNGEST CHILD)?	No. of months ☐☐	

14.	Why did you stop breastfeeding (NAME OF YOUNGEST CHILD)?	Mother ill/weak..... 1 Child ill/weak..... 2 Child died..... 3 Nipple/breast problem..... 4 Insufficient milk..... 5 Mother working..... 6 Child refused..... 7 Weaning age..... 8 Became pregnant..... 9 Started using contraception.....10 Other_____11 (Specify) Not stopped.....98	
15.	Do you have a card where (NAME OF YOUNGEST CHILD'S) vaccinations are written down? If YES, may I see it please?	Yes, seen..... 1 Yes, not seen..... 2 No card..... 3	→SKIP TO Q17 →SKIP TO Q18
16.	Did you ever have a vaccination card for (NAME OF YOUNGEST CHILD)?	Yes..... .. 1 No..... .. 2	SKIP TO Q18

17.	COPY VACCINATION DATES FOR EACH VACCINE FROM THE CARD. WRITE “88" IN “DAY” COLUMN IF CARD SHOWS THAT A VACCINATION WAS GIVEN, BUT NO DATE RECORDED.	DAY MO YR BCG _____/_____/_____ DPT1 _____/_____/_____ DPT2 _____/_____/_____ DPT3 _____/_____/_____ POLIO 1 _____/_____/_____ POLIO 2 _____/_____/_____ POLIO 3 _____/_____/_____ MEASLES _____/_____/_____	
18.	Did (NAME OF YOUNGEST CHILD) ever receive any vaccination to prevent his/her from getting disease?	Yes..... 1 No..... 2 DK..... 8	2 OR 8 →SKIP TO Q20

19.	Please tell me if (NAME OF YOUNGEST CHILD) received any of the following vaccinations: A BCG vaccination against tuberculosis, that is, an injection in the left shoulder that caused a scar? A DPT vaccination against diphtheria, pertussis, and tetanus, that is, an injection in the thigh? If YES, how many times? Polio vaccine, that is, drops in the mouth? If YES, how many times? An injection against measles?	Yes..... 1 No..... 2 DK..... 8 Yes..... 1 No..... 2 DK..... 8 Number of times ☐ Yes..... 1 No..... 2 DK..... 8 Number of times ☐ Yes..... 1 No..... 2 DK..... 8	
20.	Has (NAME OF YOUNGEST CHILD) been ill with a cough in the last two weeks?	Yes..... 1 No..... 2 DK..... 8	2 OR 8 →SKIP TO Q25
21.	Was anything given to treat the cough?	Yes..... 1 No..... 2 DK..... 8	2 OR 8 →SKIP TO Q23

22.	What was given to treat the cough? Anything else? RECORD ALL MENTIONED.	Increased fluids..... 1 Continued feeding..... 2 Used home remedies/herbal medicine.....3 Antibiotic..... .. 4 Cough syrup..... 5 Other_____ 6 (Specify)	
23.	Did you seek advice or treatment for the cough?	Yes..... .. 1 No..... .. 2	→SKIP TO Q25
24.	Where did you seek advice or treatment for the cough?	PUBLIC SECTOR Gvt. Hosp/clinic/CHHC..... 1 Rural Health Unit (RHU).....2 BGY Health Station (BHS)..... 3 Mobile Clinic..... 4 Community Health Worker.....5 MEDICAL PRIVATE SECTOR Pvt. Hospital/clinic..... 6 Pharmacy..... .. 7 Private doctor..... 8 Mobile Clinic..... 9 Community Health Worker.....10 OTHER PRIVATE SECTOR Store.....11 Hilot/Herbolario.....12 Other.....13	

25.	Has (NAME OF YOUNGEST CHILD) had diarrhea in the last two weeks?	Yes..... .. 1 No..... .. 2 DK..... .. 8	2 OR 8 →END
26.	Was there any blood in the stools?	Yes..... .. 1 No..... .. 2 DK..... .. 8	
27.	Was (NAME OF YOUNGEST CHILD) given the same amount to drink as before the diarrhea, or more, or less?	Same..... .. 1 More..... .. 2 Less..... .. 3 DK..... .. 8	
28.	Was anything given to treat the diarrhea? Anything else? RECORD ALL MENTIONED.	Fluid from ORS packet..... 1 Rice water/"AM"..... 2 Antibiotic (pill or syrup)..... 3 Other pill or syrup..... 4 Injection..... .. 5 (I.V.) Intravenous..... 6 Home remedy/herbal medicines.....7 Other_____ 8 (Specify)	
29.	Did you seek advice of treatment for the diarrhea?	Yes..... .. 1 No..... .. 2 DK..... .. 8	2 OR 8 →END

30.	Where did you seek advice or treatment?	PUBLIC SECTOR Gvt. Hosp/clinic/CHHC..... 1 Rural Health Unit (RHU).....2 BGY Health Station (BHS)..... 3 Mobile Clinic..... 4 Community Health Worker.....5 MEDICAL PRIVATE SECTOR Pvt. Hospital/clinic..... 6 Pharmacy..... .. 7 Private doctor..... 8 Mobile Clinic..... 9 Community Health Worker.....10 OTHER PRIVATE SECTOR Store.....11 Hilot/Herbolario.....12 Other.....13	

END INTERVIEW

ANNEX 3
Sample FP Rider Survey Questionnaire

CONFIDENTIALITY: All information obtained about any individual respondent will be held strictly confidential.

1996 FAMILY PLANNING RIDER SURVEY

PROV..... ☐☐
MUN..... ☐☐
BGY..... ☐☐☐☐
HCN..... ☐☐☐☐
LN..... ☐☐

Name of Eligible Woman:

Self-administered?
1. SAQ
2. Personal interview

Reason for non-response:
1. Refused
2. Respondent not around/not available
3. Household not around/moved out
4. Others (specify)_____

No.	Questions	Coding Categories	Skip To
1	How old were you on your last birthday?	Completed years..... ☐☐	
2	In what month and year were you born?	Month .....☐☐ Year.. .....☐☐	
3	How many children have you had during your life, including those who were borh alive but died later, those who are living with you now and those who are living somewhere else?	Total No. of Children ....☐☐ If NONE, ENTER 'OO'.....	 → 7
4	Did you have any live birth anytime from July 1, 1993 to the present (DATE OF INTERVIEW)?	Yes ..... 1 No 2	→ 7
5	How many are these five births? (Since July 1, 1993)	No. of Live Births ..... ☐	
6	In what month and year were these live births born? CIRCLE THE MONTH UNDER THE APPROPRIATE YEAR FOR EACH BIRTH ON THE CHART BELOW. IF THERE WERE MULTIPLE BIRTHS (TWINS, TRIPLETS, ETC) IN ANY MONTH, RECORD THE NUMBER OF BIRTHS ABOVE THE MONTH. ENTER APPROPRIATE NUMBERS IN THE BOXES PROVIDED STARTING WITH THE NUMBER OF BIRTHS FOLLOWED BY THE MONTH AND THE YEAR OF BIRTH.	m m y y Example: 2 0 4 9 3	

	1993	1994	1995	1996	
	J A S O N D u u e e e e l g p e v c	J F M A M J J A S O N D a e a p a uu ue eo e n b r r y ni g pt v e	J F M A M J J A S O N D a e a p auuu e c e e n b r r y nlg p t v s	J F M A M J J a e a p a u u n b r r y n l	

7	Are you currently pregnant?	Yes ..... 1 No..... 2	→ 17
8	Has your partner ever had an operation to avoid having children?	Yes ..... 1 No..... 2	→ 10
9	In what month and year was the vasectomy/ sterilization operation performed?	Month .....☐☐ Year.. .....☐☐ IF MONTH IS UNKNOWN, ENTER DK.	

10	Have you ever had an operation to avoid having children?	Yes ..... 1 No..... 2	→ 12
11	In what month and year was the ligation/sterilization operation performed? IF MONTH IS UNKNOWN, ENTER DK.	Month .....☐☐ Year.. .....☐☐	→ 14
No.	**Questions**	**Coding Categories**	**Skip To**
12	Are you currently doing something or using any method to delay or avoid getting pregnant?	Yes ..... 1 No..... 2	→ 14
13	Why not? IF MORE THAN 1 REASON, ENCIRLE CODE FOR MAJOR REASON.	Wants children.....01 Side effects .....02 Lack of knowledge .....03 Health concerns.....04 Inconvenient..... 05 Opposed to family planning.....06 Prohibited by religion ..... 07 Costs too much .....08 Hard to get method..... 09 Menopausal/had hysterectomy.....10 Old/difficult to get pregnant .....11 Infrequent sex/husband away.....12 Amenorrhea.....13 Not marrried/Not sexually active ..... 14 Others (specify)..... 15	→ 17 → 17 → 17 → 17 → 17 → 17 → 17 → 17 → 17 → 17 → 17 → 17 → 17 → 17 → 17 → 17 → 17 → 17 → 17
14	Which methods are you <u>currently</u> using?	Pill.....01 IUD .....02 Injection.....03 Diaphragm/Foam/Jelly/Cream..... 04 Condom..... 05 Ligation/Female Sterilization..... 06 Vasectomy/Male Sterilization.....07 Calendar/Rhythm/Periodic Abstinence..... 08 Mucus/Billing/Ovulation.....09 Thermometer/Temperature.....10 Lactational/Amenorrhea Method (LAM).....11 Other natural family planning methods.....12 Withdrawal.....13 Others (specify) 14	→ 16 → 16 → 16 → 16 → 16 → 16 → 16 → 17 → 17 → 17 → 17 → 17 → 17 → 17 → 17

15	IF THE ANSWER IN QUESTION 14 IS IUD 902) In what month and year was the IUD inserted?	Month .....☐☐ Year.. .....☐☐ IF MONTH IS UNKNOWN, ENTER DK.	
No.	**Questions**	**Coding Categories**	**Skip To**
16	Where did you avail of the methods you are currently using (ANSWERS IN QUESTION 14)?	Name of Facility Pill. _____ ☐☐ IUD._____ ☐☐ Injection. _____ ☐☐ Diaphragm/Foam/Jelly/Cream _____.. ☐☐ Condom _____.. ☐☐ Ligation/Female Sterilization _____.. ☐☐ Vasectomy/Male Sterilization _____.. ☐☐	
17	Are you single, currently married, living together, separated, divorced or widowed?	Single/Never married.....1 Currently married .....2 Living together .....3 Separated/Divorce .....4 Widowed 5	
E N D I N T E R V I E W			